DISSEMINATION WORKSHOP REPORT

Practices and experiences in enhancing sustainability of program gains in the Lake Zone

SEPTEMBER 2014

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Acronyms

CBO	Community-based organization
CHMT	Council Health Management Team
CM	Case management
DMO	District Medical Officer
HCW	Health care worker
HF	Health facility
IMCI	Integrated management of childhood illness
MoHSW	Ministry of Health and Social Welfare
MSH	Management Sciences for Health
NMCP	National Malaria Control Program
PQIT	Pediatric quality improvement teams
RHMT	Regional Health Management Team
RMO	Regional Medical Officer
THP	Tibu Homa Program
URC	University Research Co., LLC
USAID	United States Agency for International Development
ZHRC	Zonal Health Resource Centre

ABSTRACT

Over the past three years, the Tibu Homa Program (THP) has been working to improve case management of children under five with fevers in the Lake Zone (Kagera, Mara, Mwanza, Geita, Shinyanga, and Simiyu regions) of Tanzania through system-strengthening interventions. The Lake Zone was identified by the Ministry of Health and Social Welfare (MoHSW) and the United States Agency for International Development (USAID) because of its high (above the national average) under-five mortality rate and high prevalence of malaria.

The THP emphasizes approaches that can be sustained over time. The program's interventions in case management and supply chain management aim to improve diagnosis and management of fever at the facility level. Its community strategy, which aims to improve knowledge among caretakers to bring children with fever to a health facility within 24 hours of onset of fever, further helps to create demand from the community for these improvements.

The program is engaged with the MoHSW Integrated Management of Childhood Illnesses (IMCI) Unit and the National Malaria Control Program at all levels of the health system, including working with the Zonal Health Resource Center in Mwanza and the Regional and Council Health Management Teams (RHMTs/CHMTs). The program has set up pediatric quality-improvements teams at the health-facility level and is building the capacity of RHMTs and CHMTs in planning, budgeting, and resource mobilization, as well as engaging the private sector in the mobilization of additional resources.

Results include buy-in of the program's activities by the regional and council leadership; activity follow-up by the RHMTs and CHMTs; and improving awareness at the community level of the need to engage with health facilities and take children under five years of age to a health facility within 24 hours of the onset of fever. Compliance with first-line treatment for outpatient malaria cases has been kept above 90%. On the average, 93% of the reporting facilities (170) had more than 10 of the 22 tracer items from April through June, 2014, compared to 42% at baseline in January 2012. Many challenges remain with regard to further strengthening the RHMTs and CHMTs and restructuring them to manage the health facilities more effectively and build their commitment to monitoring, mentorship, and supportive supervision.

A participatory approach to strategy development for sustainability is a viable approach to achieving stakeholder buy in. Sustained monitoring, mentorship, and supportive supervision are very dependent on how well the regional and council teams and facility managers are motivated and supported by the regional and council administrative leadership.

I. INTRODUCTION

The 2010 Tanzania Demographic and Health Survey[1] showed a mortality rate of 51 for infants and 81 for children under five years of age of per 1,000 live births, nationally, and 64 (infants) and 109 (children under five) per 1,000 live births for the Lake Zone. These high rates prompted the United States Agency for International Development (USAID) and the Ministry of Health and Social Welfare of Tanzania (MoHSW) to design the Tibu Homa Program (THP) to improve the diagnosis and management of severe febrile illness in children under five years of age in the Lake Zone of Tanzania (Mwanza, Mara, Kagera, Shinyanga, Simiyu, and Geita regions).

Tibu Homa Program is implemented by University Research Co., LLC (URC), in collaboration with Management Sciences for Health (MSH) and Amref Health Africa. The program, team partners with the MoHSW and Regional and Council Health Management Teams to transform the current presumptive diagnosis and management of febrile illness into a system where rapid diagnostic tests play a central role, increasing proper diagnosis and proper treatment, based on the diagnosis. This is done through classroom training of health care workers (HCWs) in case management, logistics management, and quality improvement methods using the Model of Improvement (including rapid-improvement cycles) and providing on-the-job training through monthly supportive supervision/coaching and clinical and logistic mentorship, together with Regional Health Management Teams (RHMTs) and Council Health Management Teams (CHMTs). This collaborative effort in training and supportive supervision "ensures that workers know exactly what tasks they are expected to perform, have the necessary resources to perform these tasks, and receive feedback that assists them in achieving their tasks."[2]

Sustainability is one of the three key objectives of the program and was included as an intervention component in THP's planning and design stage. To ensure that improvement gains are sustained, the program has been implementing a number of interventions. The purpose of this paper is to describe the program's experience in implementing sustainability activities, specifically:

1) Highlight the methodology and interventions used and
2) Highlight the results to date and experiences in sustaining gains made.

II. METHODOLOGY

During the planning and design stage, THP engaged key decision makers and stakeholders in a discussion on the issues and challenges to achieving sustainability of child health interventions in the Lake Zone area, and how these can be addressed. The discussion explored policy-related issues, including sustaining regional/district officers and health managers' capacity through didactic training, on-the-job training, mentoring, and supportive supervision; and sustaining the program integration and synergies with the Pediatric Health Initiative, the National Malaria Control Program (NMCP), and the Integrated Management of Childhood Illness (IMCI) unit. Others issues discussed include sustaining innovative approaches to engage funders, implementing partners, target groups and the private sector; sustaining the provision of quality services at facilities through engagement of non-governmental organizations and private practitioners; sustaining health care workers' and facilities' capacity in collecting and using data to improve case management; sustaining the capacity of local training institutions, such as the Zonal Health Resource Centre (ZHRC), in scaling up training for case management, leadership, and financial management and

[1] Tanzania Demographic and Health Survey, National Bureau of Statistics, Dar es Salaam, Tanzania; ICF Macro, Calverton, Maryland USA, April 2011.
[2] Bradley et al. District health managers' perceptions of supervision in Malawi and Tanzania, 2013. Retrieved from http://www.human-resources-health.com/content/11/1/43.

supporting electronic IMCI trainings; and creating and sustaining community demand for quality services.

From the workshop's recommendations, the following strategies were adopted:

1) Engage IMCI/NMCP (at all levels), ZHRC and RHMTs/CHMTs: THP is now working with the IMCI and NMCP at the national, regional, and district levels to ensure institutionalization of improvement gains and ownership of activities, such as supportive supervision, data management, case management (CM), and supply-chain-management trainings. The ZHRC has been engaged to ensure scaling up of case management and financial management trainings.
2) Work with pediatric quality-improvement teams (PQITs) to improve case management (CM) ownership at the facility level by ensuring continued availability of malaria rapid-diagnostic tests and anti-malarial drugs and by ensuring the existence and functionality of a system to continuously train facility-based personnel on CM.
3) Build capacity of RHMTs and CHMTs in financial management, with a special focus on planning, budgeting, and resource mobilization.
4) Increase the capacity and commitment of regional, and particularly district, officers to monitor and supervise case management.
5) Ensure private sector support, including the potential mobilization of additional resources, thus creating a mechanism for accountability (including incentives) for the quality of CM.
6) Improve data management and plans at all levels by testing, identifying, and disseminating successful, facility-level interventions and developing an approach to increase the perceived benefits of improved case management.

This approach, as discussed by the stakeholders at the strategy workshop, fits well with the THP design, which states that:

"*The ultimate goal of this program is to reduce mortality of children under five with severe febrile illness through increasing proper diagnosis and treatment of febrile illness cases in the Lake Zone. In order to achieve this, this program will achieve the objectives of increasing availability and accessibility to essential facility-based curative and preventive child health services;* ***ensuring sustainability of critical child health activities****; and increasing linkages within the community to promote healthy behaviors."*[3]

III. RESULTS

THP directly engaged key decision makers at the regional and council levels in dialogue on sustainability. These meetings also served as a forum to challenge the RHMTs, CHMTs, and facility managers to think about, identify, and take up some activities that the program had initiated or revitalized. Obtaining buy-in from key players—including the Regional Administrative Secretary, regional medical officers (RMOs), district executive officers, the National Malaria Control Program, and the IMCI unit, among others—has been instrumental in enabling the program to move forward on sustainability, thus achieving the following results:

1. The RHMTs and CHMTs from 19 districts[4] and the four regions of Mwanza, Kagera, Mara and Geita have met, discussed, and agreed on action points to sustain activities in their respective districts. Some of these teams have started taking the lead on some of the areas, which include supportive supervision and mentorship and data management. Results from these workshops include:

[3] "Diagnosis and management of severe febrile illnesses." Technical proposals to USAID/Tanzania 10-011-RFA October 29 201, URC.

[4] Tarime, Musoma Rural, Serengeti, Geita, Muleba, Missenyi, Serengeti, Rorya, Bunda, Magu, Nyamagana, Misungwi, Biharamulo, Ngara, Karagwe, Ilemela, Ukerewe, Kwimba, and Chato.

- Financing and distribution of outpatient cards for children under five to their health facilities (two CHMTs).
- All Karagwe District health facilities' operating accounts are managed by the facility health committees.
- Notable RHMT and CHMT ownership of planning and implementation of THP-supported activities: for example, the Mara RMO followed up on poorly performing facilities in his region.

2. Nineteen CHMTs and three RHMTs have been trained in financial management, focusing on budgeting, planning, and resource mobilization. The following results originate from proposals developed by participants after financial management training:
   - Plans to renovate a pediatric ward at a district hospital with funds from a local donor.
   - Reproductive and Child Health Services received a speed boat to serve difficult-to-reach marshy islands in Lake Victoria as a result of a proposal submitted by Muleba District to a local organization.
   - Awareness among the community/village leadership regarding linking with health facilities to improve care of children under five.
3. As a result of eighty-three village/street government meetings, specific community strategies have been agreed upon to identify, monitor, and refer children under five to a health facility within 24 hours of onset of fever.
4. One hundred sixty-two community health workers are active in seven districts.
5. Through the creation of pediatric quality-improvement teams, HCWs in 393 health facilities have the skills to solve basic problems at the facility level.
6. There has been a notable improvement in the proportion of facilities collecting and using data (67% in March, 2014, compared to 46% in March, 2013). Some R/CHMTs now use data for decision making.
7. There has been a 60% increase in the number of households enrolled in the Community Health Fund in Missenyi District after one round of campaigns: before the campaign, 320 households were enrolled and after the campaign, the number increased to 513. Although this is only a tiny fraction of population in the Lake Zone, this indicates potential to increase coverage in the entire zone.

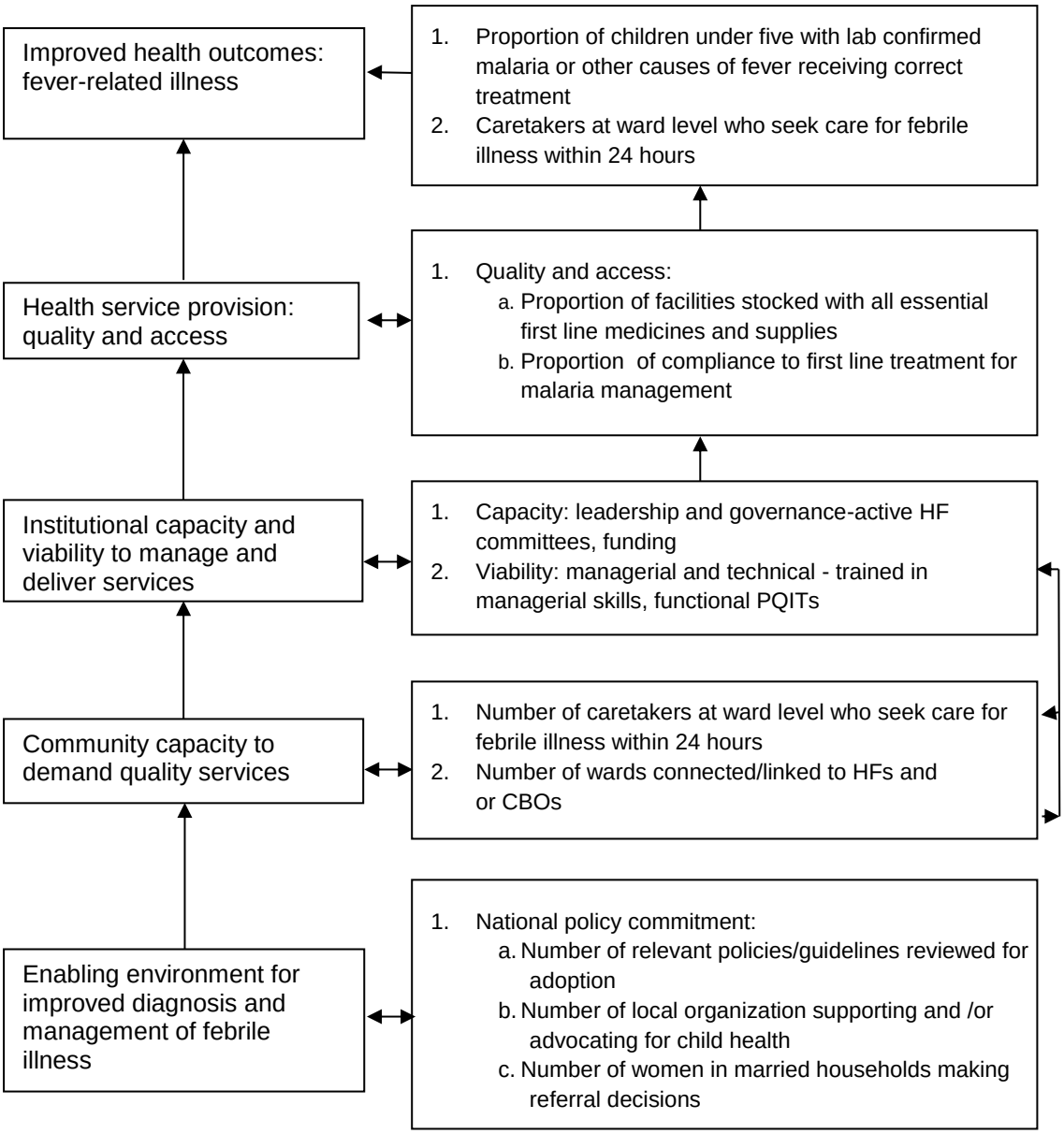
IV. DISCUSSION

To sustain program activities, there is a need for in-country, region, and council capacity to:

1) Provide continued mentorship and supervision to maintain case management standards
2) Monitor and constantly provide supportive supervision
3) Access technical and financial resources to maintain program activities
4) Obtain national commitment to the adopted approaches to sustain the program

In order to track progress, the THP has used a basic framework, shown in Figure 1, which takes into account the level of current capacities of communities and health institutions that THP has reached and how this contributes to improvements in program implementation.

Figure 1: Framework for Addressing Sustainability of Gains in Diagnosis and Management of Severe Febrile Illness in the Lake Zone, Tanzania



As the sustainability implementation continues to evolve, the Tibu Homa Program will continue to monitor progress, as per the framework above.

Enabling Environment for Improved Diagnosis and Management of Febrile Illness

Currently there is an enabling environment nationally to support improved diagnosis and management of severe febrile illnesses. The National Malaria Control Program and the IMCI unit of the MoHSW at the national level subscribe to national guidelines designed to improve diagnosis and management of severe febrile illness in children under five years of age. Both organizations worked with THP to update the national IMCI guidelines.

Community and Institutional Capacity

THP has engaged communities in the Lake Zone to promote awareness of febrile illness at the community level. In combination with facility outreach clinics, the proportion of children under five years of age seen by a skilled provider within 24 hours of the onset of fever has improved, from 10% in February, 2012 to 44% in March, 2014 (midterm target 20%). Institutional capacity is showing improvement. As discussed above, 393 health facilities in the Lake Zone use active work improvement teams (PQITs), which include HCWs with improved skills, to address a myriad of basic problems that are usually barriers to improved performance.

In general, it is clear that national, regional, and council leadership value the importance of program sustainability. This is exemplified by their consistent attendance at key meetings addressing sustainability organized by the program. Experience has shown, however, that participation in such meetings does not always result in follow up on action points agreed upon during the meetings. Often, the action points are allocated to individual RHMT and CHMT members, who rarely execute them—a weakness in RHMT and CHMT management. Ostensibly, all responsibility for follow up rests with the RMO or the district medical officer (DMO). These two officials shoulder a heavy staff management load, making it difficult for them to follow up on every action point assigned.

Evidence from the THP training program shows that most of the RHMT and CHMT members in the regions covered by the program have acquired one or more of the technical and/or management skills necessary to resolve service delivery problems, though training in supportive supervision, planning and financial management, and in clinical and supply-chain mentorship. These trainings have emphasized well-researched topics, such as strengthening communication, focusing on problem solving, facilitating team work, and providing leadership and support. In addition, tools for performance assessment and structured feedback have been made available.

Health Service Provision

At the service delivery level, there is evidence of improved services, as seen below:

- Compliance with first-line treatment for outpatient malaria cases has been maintained above 90%.
- Proportion of facilities stocked with tracer list of essential, first-line medicines and supplies at the time of the visit (more than 10) has increased. On the average, 93% of the reporting facilities (170) had more than 10 of the 22 tracer items from April to June, 2014, compared to 42% at baseline in January, 2012.
- Over 70% of children under five with fever who get tested receive the correct anti-malarial treatment, a proxy for improved health outcomes.

Improved Health Outcomes

While a three-year period is inadequate to demonstrate health outcomes, it is clear that children under five in the Lake Zone receiving malaria test services have increased, from 45% in February, 2012, to 90% in June, 2014; those being seen by a skilled provider within 24 hours of the onset of fever has increased from 5% in February, 2012, to 44% in June, 2014. In addition, 94% of children under five testing positive for malaria are receiving the correct, first-line anti-malarial, and the percentage receiving treatment according to standard guidelines has improved from 3% in February, 2013, to 39% in June, 2014.

Despite these notable achievements, challenges do remain:

- RHMTs and CHMTs are often pulled in several directions by competing demands; hence, a holistic commitment and approach to program activities as part of their day-to-day duties is limited. Participation in support supervision may miss some critical team members, due to other chores.

- District heads often send “acting officers” to meetings and briefings. These acting officers cannot make decisions at these meetings and don’t communicate the decisions made back to their superiors and peers.
- Challenges that may reflect poorly on the performance of the CHMTs themselves are often not included in briefings to superiors.

V. CONCLUSION AND RECOMMENDATIONS

Tibu Homa Program’s experience enhancing program sustainability has demonstrated that a participatory approach to strategy development is the most viable method to obtain stakeholder buy in; this approach is most effective if built into the program design from the start. Secondly, involving key stakeholders in follow up at the implementation level is important, as it helps mentor the local management teams and facility-level mentors to continue services without the program’s support. And lastly, mobilizing communities to demand quality services helps to engage health facility teams to improve service delivery.

While the RHMTs and CHMTs mean well, they seem to lack the human resource skills or authority to instill change in behavior among health facility staff. The staff turnover within team membership and within health facilities often disrupts progress made. There is a need to further decentralize accountability authority so that the DMO has, for example, full disciplinary authority over health facility managers. A motivational strategy to change the behaviors of the RHMTs, CHMTs, and health staff is lacking.

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